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SUPREME COURT OF THE STATE OF NEW YORK — NEW YORK COUNTY

PRESENT: LOBIS Justice PART 6

FAULKNER, DEMIAN

-v-

JOSEPH HARTZ, M.D., ET AL.

INDEX NO. 402048/09

MOTION DATE 6/4/13

MOTION SEQ. NO. 01

MOTION CAL. NO. ____

The following papers, numbered 1 to 24 were read on this motion to (for) summary judgment

	PAPERS NUMBERED
Notice of Motion/ Order to Show Cause — Affidavits — Exhibits ...	1-11
Answering Affidavits — Exhibits	12-19
Replying Affidavits	20-24

Cross-Motion: ☐ Yes ☑ No

Upon the foregoing papers, it is ordered that this motion

THIS MOTION IS DECIDED IN ACCORDANCE WITH THE ACCOMPANYING MEMORANDUM DECISION and Order.

MOTION/CASE IS RESPECTFULLY REFERRED TO JUSTICE FOR THE FOLLOWING REASON(S):

Dated: 8/22/13

JOAN B. LOBIS J.S.C.

Check one: ☐ FINAL DISPOSITION ☑ NON-FINAL DISPOSITION

Check if appropriate: ☐ DO NOT POST ☐ REFERENCE

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SUPREME COURT OF THE STATE OF NEW YORK
NEW YORK COUNTY: IAS PART 6

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DEMIAN FAULKNER, As Administrator of the Goods, Chattels and Credits which were of AMELIA FAULKNER SIEBERS, Deceased,

Plaintiff,

-against-

JOSEPH MARTZ, M.D., and BETH ISRAEL MEDICAL CENTER,

Defendants.

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Index No. 402048/09

Decision and Order

JOAN B. LOBIS, J.S.C.:

Joseph Martz, M.D., and Beth Israel Medical Center move for summary judgment pursuant to Rule 3212 of the Civil Practice Law and Rules. Plaintiff Demian Faulkner, as the Administrator of the Goods, Chattels and Credits of Amelia Faulkner Seibers, deceased, opposes the motion. For the following reasons, the motion is denied.

This medical malpractice action involves the treatment rendered to Amelia Faulkner Siebers by defendants in December 2008. Ms. Faulkner Siebers was diagnosed with rectal cancer in November 2005. Her medical history indicated that she was also HIV positive and had Hepatitis C. On May 2, 2006, the decedent underwent a low anterior resection with diverting loop ileostomy at Beth Israel Medical Center (BIMC).[1] The surgery was performed by defendant Joseph Martz, M.D., a colorectal surgeon. The ileostomy remained in place for two years as Ms. Faulkner Siebers continued to treat at BIMC. During that time, she experienced a remission of her rectal cancer.

[1] An ileostomy is a surgical opening constructed by bringing the end of the small intestines out onto the surface of the skin.

On September 15, 2008, Ms. Faulkner Siebers presented to Dr. Martz for consultation to discuss the closure and reversal of the ileostomy. During that visit, Dr. Martz noted that she had significant inflammation in the cecum. In the nine months prior to that visit, the patient had undergone a series of radiological studies at BIMC, which were significant for findings of a persistent sinus tract, inflammatory process in her pelvis and abdomen, colonic diverticula, and a collapsed colon.

On December 9, 2008, the patient underwent the ileostomy closure performed by Dr. Martz. The operative dictation indicates that Dr. Martz created a side-to-side anastomosis[2] and excised the ileostomy. The procedure was completed without any noted complications.

Following the procedure, the patient complained of pain and had a distended abdomen. The pain was controlled with medication. The patient's blood count was normal, and she had no fever. On December 13, 2008, the patient was noted to have passed gas, and the defendants had intended to discharge the patient the following day. On December 14, 2008, however, the patient did not pass gas, and Dr. Martz decided to continue her admission to the hospital and keep her for further observation.

On December 15, 2008, the patient was noted to have developed a "mild" abdominal

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[2] An anastomosis is a surgical connection between two structures, such as blood vessels or loops of intestine.

distention, which, according to Dr. Martz, was due to her morphine use. A CT scan of her abdomen showed the presence of ascites, which are accumulations of serous fluid in the peritoneal cavity. Small amounts of air and gas were also found in the patient's abdominal cavity. On December 16, the patient's abdominal distention progressed from mild to severe. She also experienced tenderness and tachycardia. Dr. Martz performed a re-exploration procedure that day, and the patient was noted to have a necrotic colon with cecal perforation and fecal peritonitis. The operative notes indicate that the patient experienced colonic ischemia involving the cecum, ascending colon, transverse colon, and descending colon. Part of the cecal wall had thinned, and the cecum was perforated. The area was also found to be contaminated. Dr. Martz performed a subtotal colectomy and resected the colon.

After the surgery on December 16, 2008, the patient remained sedated and intubated. Her condition deteriorated, and on December 26, the patient died. The autopsy report lists the cause of death as "septic complications of peritonitis due to cecal perforation complicating ischemia of large intestine following reversal of ileostomy performed for the treatment of rectal cancer."

Plaintiff commenced this action on June 17, 2009, alleging that the decedent's injuries and death were proximately caused by an anastomotic leak secondary to a persistent sinus tract leak, inflammation, and the improper performance of the ileostomy reversal. Plaintiff also has a cause of action for lack of informed consent.

Dr. Martz and BIMC seek summary judgment on all causes of action. They contend

that the patient's anastomosis did not leak and that the decedent suffered from a post-operative infection unrelated to Dr. Martz's procedure on December 9, 2008. They also argue that the patient gave her informed consent for the surgery.

The defendants submit the expert affirmation of Randolph Steinhagen, M.D., who indicates that he is a physician licensed to practice in New York and board certified in Colon and Rectal Surgery. After reviewing the relevant documents in the case, he opines to a reasonable degree of medical certainty that the treatment rendered by defendants was within the standard of care. In outlining the treatment, the expert opines that, although the patient had a persistent sinus tract requiring further treatment, it did not present an increased risk with regard to the ileostomy reversal. He states that it was proper for Dr. Martz to have performed the procedure by creating a side-to-side anastomosis prior to excising the anastomosis and returning it to the abdominal cavity. He states that the patient's complaints of post-operative pain with a distended abdomen were not unusual given her recent surgery. He further notes that, although the CT scan of December 15, 2008, showed the presence of ascites, fluid and gas in the abdomen, there was no definitive abscess. He adds that there was also no evidence of peritonitis or any emergent issue requiring surgery at that time.

Dr. Steinhagen opines that the re-exploration on December 16, 2008, was necessary to address the patient's increased abdominal distention. The re-exploration revealed the presence of colonic ischemia and gangrene, which resulted in the resection of the patient's colon. The expert explains that colonic ischemia results from inadequate blood supply and can cause sepsis, bowel infarction, or death. He states that the patient exhibited no change in her condition that would have

warranted any treatment prior to December 16, 2008.

During the re-exploration, the expert notes that the ileostomy closure site was found to have been intact and without significant inflammation. Dr. Steinhagen provides a representative diagram and accompanying legend to visualize the relevant anatomical area. He concludes that there exists no causal relationship between the ischemic necrotic bowel from which the patient suffered and the ileostomy closure at issue. He states that the closure site is not located within the area of ischemia and gangrene. The expert adds that the pathology report disproves plaintiff's theory that there had been a small intestinal anastomotic leak, since the report indicated that "there were no gross perforations, tumor masses, or areas of obstruction." Dr. Steinhagen states that decedent, in fact, suffered from colonic perforation, which produced fecal peritonitis and sepsis.

In opposition, the plaintiff argues that summary judgment should be denied as there exist triable issues of fact. Plaintiff submits the expert affirmation of a physician who is licensed in New York and is board certified in general and thoracic surgery. The expert states that the expert is familiar with the standard of care in performing ileostomy closures and in the management of bowel ischemia. The expert opines in relevant part that the performance of the ileostomy reversal was contraindicated because the patient's chances for a successful outcome were extremely poor. He points to the radiological studies that were performed in June and September 2008, which found persistent sinus tract, an inflammatory process in the patient's pelvis, colonic diverticula, and a collapsed colon. The expert further notes that the patient's history of being HIV positive and having Hepatitis C also indicated that she had a compromised immune system. The expert further notes that

defendants were aware of her history and acknowledged the patient's inability to completely heal following prior procedures. The expert opines that the defendants did not perform sufficient tests to ensure that the patient's sinus tract and inflammation were fully resolved prior to the surgery on December 9, 2008, since the last radiological studies was performed in September 2008.

The expert further opines that the defendants failed to monitor the decedent post-operatively, which delayed their diagnosis and treatment of her complications. The expert notes particularly that on December 14, 2008, when the defendants canceled the patient's discharge due to her failure to pass gas and lack of bowel movement, they should have examined her carefully, ordered a CT scan of her abdomen, and eliminated any suspicion for infection. The expert, however, indicates that the CT scan was not ordered until December 15, 2008.

In reply, the defendants state that the plaintiff's expert's affidavit contains misstatements and that the expert's opinion is unsupported by the record. The defendants take particular issue with plaintiff's claim that the preoperative studies were insufficient. To further support their position, they submit the expert affirmation of Mark Flyer, M.D., a board certified radiologist, who states in relevant part that the pre-operative radiological studies showed that there had been minimal inflammation at the area of the sinus tract leak.

In considering a motion for summary judgment, this Court reviews the record in the light most favorable to the non-moving party. E.g., Dallas-Stephenson v. Waisman, 39 A.D.3d 303, 308 (1st Dep't 2007). A movant must support the motion by affidavit, a copy of the pleadings, and

other available proof, including depositions and admissions. C.P.L.R. Rule 3212(b). The affidavit must recite all material facts and show, where a defendant is the movant, that the cause of action has no merit. Id. This Court may grant the motion if, upon all the papers and proof submitted, it is established that the Court is warranted as a matter of law in directing judgment. Id. It must be denied where facts are shown "sufficient to require a trial of any issue of fact." Id.

In a medical malpractice case, to establish entitlement to summary judgment, a physician must demonstrate that he did not depart from accepted standards of practice or that, even if he did, he did not proximately cause injury to the patient. Roques v. Noble, 73 A.D.3d 204, 206 (1st Dep't 2010). In claiming treatment did not depart from accepted standards, the movant must provide an expert opinion that is detailed, specific and factual in nature. E.g., Joyner-Pack v. Sykes, 54 A.D.3d 727, 729 (2d Dep't 2008). Expert opinion must be based on the facts in the record or those personally known to the expert. Roques, 73 A.D.3d at 206. The expert cannot make conclusions by assuming material facts not supported by record evidence. Id. Defense expert opinion should specify "in what way" a patient's treatment was proper and "elucidate the standard of care." Ocasio-Gary v. Lawrence Hosp., 69 A.D.3d 403, 404 (1st Dep't 2010). A defendant's expert opinion must "explain 'what defendant did and why.'" Id. (quoting Wasserman v. Carella, 307 A.D.2d 225, 226 (1st Dep't 2003)). Conclusory medical affirmations or expert opinions that fail to address a plaintiff's essential factual allegations are insufficient to establish prima facie entitlement to summary judgment. 73 A.D.3d at 206. Once a defendant establishes a prima facie case, a plaintiff must then rebut that showing by submitting an affidavit from a medical doctor attesting that the defendant departed from accepted medical practice and that the departure

proximately caused the alleged injuries. Id. at 207.

The Court finds that the defendants have established their prima facie entitlement to summary judgment by submitting competent expert opinion by Dr. Steinhagen, who concludes that the ileostomy procedure was properly performed on December 9, 2008, that the patient's post-operative care was proper, and that the ileostomy site was anatomically distant from the necrotic bowel that lead to the patient's death.

In opposition, however, the plaintiff rebuts this showing by presenting issues of fact. The plaintiff's expert opines that, given the patient's history of HIV and Hepatitis C, her history of inadequate healing, and the radiological studies that indicated an inflammatory process in the abdomen, the ileostomy procedure was wholly contraindicated. The expert also states that updated radiological studies should have been performed to ascertain the status of plaintiff's pelvic inflammation. In addition, the expert believes that her post-operative care was inadequate. Plaintiff's expert points out that the decision on December 14, 2008, to continue the patient's admission due to her failure to pass gas should have prompted the defendants to administer immediate tests and treatment. As to the issue of causation, plaintiff's expert presents a clear theory that, by performing a contraindicated surgery on an immune-compromised patient, the defendants may have precipitated or exasperated the events that led to the patient's death, or at the very least, hastened her death. This dispute is sufficient to rebut the defendants' prima facie showing, and summary judgment on the medical malpractice cause of action must be denied .

Summary judgment on the lack of informed consent cause of action, however, is granted. A defendant moving for summary judgment on a lack of informed consent claim must demonstrate that the plaintiff was informed of the alternatives to and the reasonably foreseeable risks and benefits of the treatment, and "that a reasonably prudent patient would not have declined to undergo the [treatment] if he or she had been informed of the potential complications[.]" Koi Hou Chan, 66 A.D.3d 642, 643 (2d Dep't 2009); see also Public Health Law § 2805-d(1).

According to the plaintiff, it is irrelevant whether the defendants obtained patient's consent, since the defendants should not have performed the surgery at all. Plaintiff states that Dr. Martz should have affirmatively refused to perform the procedure, even though the patient gave her consent. Plaintiff, however, does not dispute that Dr. Martz explained the risks associated with the ileostomy closure procedure and does not dispute the authenticity of the consent form. Whether Dr. Martz should have performed the procedure is an allegation that is duplicative of plaintiff's medical malpractice claim and does not support a separate cause of action for lack of informed consent. See Perez v. Park Madison Prof'l Labs., 212 A.D.2d 271 (1st Dep't 1995). Accordingly, it is

ORDERED that the portion of the motion seeking summary judgment on the lack of informed consent cause of action is granted, and that portion of the complaint is dismissed against Joseph Martz, M.D., and Beth Israel Medical Center; it is further

ORDERED that the remainder of the motion is denied; and it is further

ORDERED that the parties shall appear for a pretrial conference on Tuesday, September 24, 2013, at 10:00 a.m.

Dated: Aug 22, 2013

ENTER:

JOAN B. LOBIS, J.S.C.